REPUBLIC OF GHANA

What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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COMMUNITIES LEADING COMMUNITIES

Where the national Community-based Health Planning and Services (CHPS) Initiative is making remarkable progress, District Health Management Teams (DHMT) move one step at a time—with communities leading other communities. Bawku West District has deployed only three Community Health Officers (CHO) but the results achieved so far surpass expectations—the use of family planning, for instance, has more than doubled in just one year!

This is how it all began

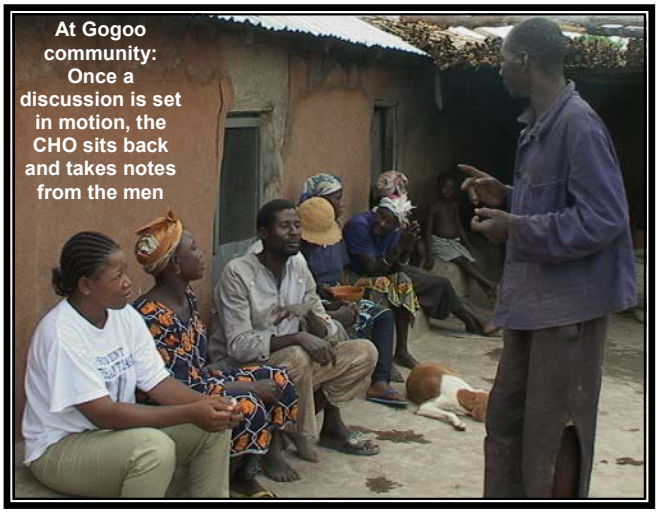
Typical compound in one of Bawku West district's leading communities served by the resident nurse

In 1999, the DHMT visited Navrongo to observe CHFP operations at the community level and interact with project staff about planning for CHPS. Upon return from Navrongo, the Bawku West DHMT moved into high gear. First, all district administrators and stakeholders were briefed on the CHPS process. In collaboration with the District Assembly they selected Tanga zone—for reasons of its remoteness and dense population—to implement CHPS as a pilot project. The area also had dedicated opinion leaders ready to support the CHO and the residents themselves were committed to seeing the Navrongo innovation bear fruit on Tanga soil. A community-sensitization durbar was held to explain the new concepts and clarify the roles of the different actors such as the CHO and DHMT; the value of community participation, contributions of the District Assembly, and input of the sub-district were also presented. The DHMT quickly refurbished an existing building that required little rehabilitation for use by the Nurse. Community-based health workers (e.g. TBAs) were active in Tanga—the community reorganized them and with the selection of a few more—assembled a corps of health volunteers to work with the CHO. The chiefs, opinion leaders, and community members showed keen interest, pledged their support, and promised to work to the best of their abilities to make CHPS successful.

A nurse was selected and trained in Navrongo and deployed. The Regional Health directorate provided her with a motorbike and supplied bicycles for the health volunteers whilst the DHMT contributed gas lamps, tape recorders, raincoats, stationery, drugs, furniture, and other logistics from the Donor Fund. But...things were too good to be true—the nurse left for further studies and the programme came to a halt—deeply damping the spirit of even ardent CHPS advocates. Still, perseverance took the better control of team members; in 2001, the district sent three Community Health Nurses to train at the NHRC. Meanwhile, volunteers continued to be active in Tanga and that kept CHPS alive until the next nurse was posted. The pieces of the puzzle were reassembled. Once success was steady, the team moved to the next community, Teshie, carrying along with them the formula for success from Tanga—communities owning the process and playing the leading role. Soon the DHMT extended services to Gogoo community far east, in fact far east enough for Gogoo to be easily mistaken for a community in Bawku East!

Commitment of the people, Chiefs and Elders, the presence of NGOs in the district—notably Action Aid—and the peace prevailing in the district have been singled out for special mention as having contributed in a significant way to the smooth implementation of CHPS in Bawku West. The DHMT Donor Fund also played a key role in getting programmes started and sustained.

All 15 steps of the CHPS process have been completed in all 14 of the district's zones and impact has been great. The innovative strategies employed improved access to basic health services and increased performance coverage—but above all—the strategies reinforced community participation in discussing health issues. The community and health worker partnership has been strengthened. There has been increased programme coverage and an increase in the number of cases seen by the CHO such as ANC, Yellow Fever, Measles, Polio3, supervised deliveries, BCG, and PNC. From 2001 and 2002 BCG rose over 30% from 410 to 607 and growth monitoring increased by 30% from 2238 to 3175. Most remarkably, family planning acceptors have more than doubled from 224 to 500. Antenatal care rose by 18% (633 to 775) but supervised deliveries went up from 218 to 310, an increase of 30%—a much better performance than happened in Navrongo under experimental conditions.


At Gogoo community: Once a discussion is set in motion, the CHO sits back and takes notes from the men

Today 21,656 people representing 26% of the population receive regular CHO services. Two more nurses have been trained to operate at Zongoire and Tilli, the next two communities on the waiting list. Five down, nine to go!

Conclusion

First, Bawku West uses its own resources, both within the DHMT and the community to get started. They target resources so that they can be sure whatever is started is finished in a zone. That is, they do not start more zones than can be actually moved forward. Second, the district taps Navrongo's resources to make progress—they used their connection with the NHRC to train four nurses. The district is sponsoring two students at the Navrongo Community Health Nurses Training School and plans to send three more nurses to train as CHO in 2003. But most importantly, they use communities to lead other communities. Once success is achieved in one community the experience is shared with another community—the successful community leads the way—serving as consultants and sources of ideas. All durbars in functioning zones are used to promote CHPS among communities not yet involved. This strategy of communities leading communities is a key innovation that merits emulation by other districts. This way CHPS will scale up gradually in tandem as new resources flow. As it were, Bawku West does not dwell on its difficulties—they just build on success!


One of Bawku West district's 4-star CHO residences at Teshie community built with support from development partners

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programmes, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation. The Community Health Compound component of the CHFP has been supported, in part, by a grant of the Vanderbilt Family to the Population Council.